FIRST STEPS FAMILY SHARE Form 14 (12-04)
INABILITY TO PAY EXEMPTION REQUEST

DATE: _____ /_____ /_____ Service Coordinator: _____ Provider # _____

Service Coordinator's Address: _____

Phone: (_____)_____ Fax: (_____)_____

SECTION A: IDENTIFYING INFORMATION

Child's Legal Name: _____ Child's Date of Birth: ____/____/____

CBIS ID # _____ Initial IFSP Date: _____/_____ /_____ Family Share Acc't # _____

Parent/Guardian's Name(s): _____ Phone: (_____)_____

Parent/Guardian's Address: _____

SECTION B: EXTRAORDINARY EXPENSES WORKSHEET

(Identify on average, "out of pocket" expenses, such as purchases, expenses, and modifications to accommodate extended/additional needs related to child's disability, and expenses related to other family members with disabilities or require extended care, such as elderly. These considerations do not extend to medical services for other family members. If more than one child in First Steps please complete an individual Exempt Request for each child.)

EXPENSE	Eligible Child ANNUALIZED	Other Family Member ANNUALIZED
Current Hospital/Medical Payments		N/A
Child Care Special Cost (difference related to disability) *Include Written Documentation*		N/A
Materials, Supplies, Modifications related to disability		
Specialized Equipment		
Medical/Health Services – related to child's disability		N/A
Special Medications		N/A
Special Food Supplements		
Transportation/Parking Cost related to disability		N/A
Health Insurance Premiums (amount not paid by employer)		N/A
Co-payments or sliding fee payments for services related to the disability		
Other:		
TOTAL ANNUAL EXTRAORDINARY EXPENSES	**$**	**$**
GRAND TOTAL ANNUAL EXPENSES	**$**	

Parent/Guardian's Signature: _____

SECTION C: FAMILY ECONOMIC & COMPOSITION WORKSHEET

Annual Income (Line 35 of 1040): $_____ No. Residing in Household: _____

Current Family Share Monthly Obligation: $_____ Current Family Share Category: _____

SECTION D: ADJUSTED INCOME AMOUNT WORKSHEET

Annual Income (Section C, 1.) $_____ - Grand Total Annual Expenses (Section B) $_____ =

Adjusted Income $_____ = New Family Share Monthly Obligation $_____ New Family Share Category_____
(Apply adjusted income with household size to determine new Family Share monthly obligation. Approval may only be granted for three [3] calendar months at a time.)

Service Coordinator's Signature: _____

MAIL TO: Family Share Administrator, Department for Public Health, Adult and Child Health Improvement - First Steps, 275 E. Main Street - HS 2WC, Frankfort, KY 40621

For Office Use Only
Date Received: _____ Approved: Yes_____ No_____ Signature: _____
cc: CBIS Approved for Months of _____